In twenty-four hours it was again full of blood, and at the end of forty-eight hours I emptied it thoroughly, and opened nine more cysts which I had not seen before, but which were now very large. I again seared all the sacs with a hot iron, and still further sought to control the bleeding with perchlor. ferri. The bleeding did not return, but the child died, partly from the shock, and partly from the loss of blood, on the fourth day after the operation.

I have seen one other case of encysted tumour, whose walls were exceedingly vascular, and from which a troublesome hemorrhage has followed. This was the case of a young miss ten years old, with a simple encysted tumour of three years' growth, situated on the back, over the lower angle of the scapula. The hemorrhage in this example continued four days, and was finally arrested, with great difficulty, by the actual cautery. I have seen, also, other cystic tumours containing a sero-sanguineous fluid, one of which at least was congenital.

It is to the multilocular cystic tumours, however, that I wish especially to call your attention, and of which this specimen is an example, since they are fortunately very rare, and, I have reason to believe, their character is not so simple as they at first seem to be. There is, in fact, a strong probability that they are all more or less erectile.

The example before you corresponds to the usual history of erectile tumours in the following circumstances: It was congenital. It was painless in its growth. Its walls and partitions were exceedingly vascular, and this vascularity extended much beyond its outer walls, and after excision, the neighbouring tissues continued not only to bleed but became rapidly and intensely swollen, as if from vascular erythema and congestion.

In its minute anatomy, also, it bears a striking analogy to erectile tumours not only, but to erectile and cavernous tissue in its normal state; the smaller spaces, or the cells in those portions where the disease had not so fully developed itself, resembling the cells of many purely erectile tumours, and especially the cells of the corpora cavernosa of the penis. The contents also of the cells was a bloody serum.

Similar multilocular cysts have been mentioned by pathologists. Mr. Paget records two, in both of which the septa were fasciculated like the walls of the right auricle, which were removed successfully. Mr. Paget thinks both of them may have had their origin in vascular nævi. That such was the fact with my little patient, who was only a year old at the time of the operation, the early history clearly shows. This specimen which I show now seems to have been a development of the natural structure of the parotid gland, but it was still erectile and congenital, and may properly be called a nævus.

It was impossible to remove this tumour entire without previous ligature of the carotid artery, and I chose to remove as much as possible and trust to suppuration.

I am not yet prepared to say how I should proceed in another similar case. It is certainly very difficult to cut them out entire, owing to the vascularity of all the structures adjacent, and to the intimate union which their walls have everywhere with these structures. In some regions such dissections would be totally impracticable. I should be unwilling again to trust to simple incision, or to partial exsection, on account both of the danger of hemorrhage and of the probable inefficiency of these measures. In the examples quoted by Paget, one of which was on the back and one on the pubis, and neither of which were congenital, the tumours were safely exsected; but the patients were much older than either of mine, and the writer has not sufficiently described the embarrassments of the operation, if any existed, to enable me to judge of its applicability to other cases.

I presume for the present we shall only attempt to cut them out entire, but my own experience might warn surgeons not to regard such procedures as always unattended with serious difficulties."—*Buffalo Med. Journ.*, Nov. 1856.

Laryngotomy for Syphilitic Disease.—Dr. Geo. Amerman, late House-Surgeon of Bellevue Hospital, narrates (*Northwestern Med. and Surg. Journ.*, Oct. 1856) an interesting case of secondary syphilis, in which laryngotomy was performed after apparent death, and the patient recovered. The subject of it was a woman,

twenty-five years of age, admitted into Bellevue Hospital, April 10, 1856. At the time of her admission, she had large bullæ over the whole upper part of the body and head. The throat was not carefully examined; and I am unable to say whether or not it was ulcerated. She had no dyspnœa or pain; her pulse was good, but her condition indicated an impaired constitution and a general syphilitic cachexia. She was ordered small doses of hyd. bi-chlo., with the tinct. cinch. co., good diet, and anodynes at night. About five hours after my visit, I was hastily summoned to her by the nurse, who told me she was dying. I found her sitting up in bed, unable to speak, and gasping for breath; her lips and ends of her fingers were livid, and the veins of the neck distended. The dyspnœa was so severe that it seemed to threaten immediate suffocation. On examining the throat, nothing was perceptible except a general redness of the fauces, which was most intense on the anterior surface of the epiglottis. Pressure over the larynx caused some pain. Inspiration was more difficult than expiration. Physical examination of the chest revealed nothing abnormal. The air entered the lungs, and was resonant throughout. It was thought expedient to try scarifications, which, however, proved useless. An emetic of zinci sulphas was next given, but without producing emesis. Her dyspnœa had now become so alarmingly urgent, that it was decided to open the air-passages. Laryngotomy was the operation proposed, as the obstruction was thought to exist in the larynx—probably at the vocal cords. Some time necessarily elapsed in preparing the instruments, &c., prior to the operation; and, just as I was about to make the first incision, the patient gave a gasp, and apparently expired. All respiration, or efforts to respire, ceased. The pulse, which had been before extremely feeble and rapid, now became more so; and, in half a minute after she ceased to breathe, her heart stopped pulsating. At the moment respiration ceased, I proceeded rapidly with the operation, and, in one and a half minutes, succeeded in introducing the tube. Artificial respiration was resorted to, and, in less than a minute (between one-half and one minute), natural respiration commenced. I think there was an absence of the respiration for at least two minutes, and of the pulse for at least one and a half minutes. The respiration ceased first, and was first restored. When the patient was fully resuscitated, her pulse, though feeble, was regular and much slower, her respiration perfectly easy, and she sank into a quiet and refreshing sleep. Some trachitis followed the operation; but her recovery was as rapid as could have been expected. She wore the tube for twelve days, when it was removed, and the wound allowed to close. Her rupia was treated with alterative doses of hyd. bi-chlo. and tinct. cinch. co.; but it seemed to have very little good effect, and, instead, large doses of iod. potassa were substituted, which acted promptly and beneficially. The large scabs became detached, and slowly separated, leaving a healthy ulcer underneath, which rapidly healed. Her recovery was complete. The wound in the throat closed, and respiration through the natural passages became free and easy.

Dr. Amerman states that, during his residence in Bellevue Hospital, laryngotomy was performed four times for syphilitic disease of the throat, and, in all the cases, the operation was successful. Two of them left the Institution entirely cured. In both, the tube was worn for a shorter time than one month, when they were able to breathe easily through the natural passages, all symptoms of disease of the throat having disappeared. The third case died, eight months after the operation, from lupus, which had extended to the base of the skull, and excited secondary arachnitis, which was the immediate cause of death. In this case, the tube was never removed. The fourth case was the one whose history I have given above. It was perfectly successful. The tube was worn for twelve days, when all signs of disease in the throat disappeared. This case is also interesting in two other particulars: *First.* As showing the necessity of the operation; and, *Secondly*, the complete relief afforded by it. So far as these cases go, they point to the conclusion already arrived at by some surgeons, that, in cases of acute disease supervening on chronic syphilitic affections of the throat, the obstruction is situated in the larynx, and that laryngotomy affords relief, and hence, being an easier operation than tracheotomy, should be performed.